

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014627

STATE FILE NUMBER

3755

FILED MAY 6 1959		Registration District No. _____		Primary Registration District No. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>None</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>				c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				Length of stay in lb _____		d. STREET ADDRESS (If outside, give location) <u>5536 Page Blvd.</u>	
e. RESIDE ON FARM Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WESTLEY</u> Last <u>ANTHONY</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unk-abt 1872</u>	
9. AGE (In years) <u>abt 87</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Pine Bluff, Ark.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13a. FATHER'S NAME <u>James Anthony</u>				13b. MOTHER'S MAIDEN NAME <u>Angela -- Unk</u>		14. NAME OF HUSBAND OR WIFE <u>Estelle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Dorothy Watson, 5536 Page Blvd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>20 YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____					
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____			
21. I attended the deceased from Death occurred at <u>OCT. 8, 1958</u> <u>7:30 P.M.</u>				to <u>APRIL 14, 1959</u> and last saw her alive on <u>APRIL 14, 1959</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. O. Vermillion, M.D.</u>				22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>4/15/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>4/17/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cemetery, Kirkwood, Mo.</u>		23d. LOCATION (City, town, or county) (State) _____	
24. FUNERAL DIRECTOR <u>Cunningham & Moore, 2405 Marcus</u>		ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>APR 16 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Under no circumstances shall any statement be made in this form to the public. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed
Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.